2020-2021 Student Health Information

THE FRANKLIN SCHOOL OF INNOVATION
An EL Education School

Student Name _____ _____ _____ **DOB:**_____

First **Middle Initial** **Last**

Student Cell Phone # (If Applicable) _____

Grade for the 2020-2021 School Year _____ **Status:** ☐ Re-enrolled FSI Student ☐ New Student

Primary Doctor Name:_____ **Doctor #:**_____

Does your Child have any of the following Diagnosed Conditions? * **Please PRINT Legibly** *

A. DRUG AND FOOD ALLERGIES
- o Penicillin/Amoxicillin
- o Latex
- o Food Allergy (please specify):_____
- o Other: _____
- o None

B. ALLERGIES/RESPIRATORY
- o Asthma
- o Bees
- o Seasonal Allergies:
- o Allergy to Dog/Cats/Animals
- o Other :_____
- o None
- **Does your student require an Epi-pen at school or with him/her for any of the above listed allergies?** YES or NO
- **Does your student require an inhaler at school or with him/her at all times?** YES or NO
- **Are any of these allergies' life threatening?** YES or NO **IF YES, please write LF next to allergy**

C. CARDIOVASCULAR
- o Fainting
- o High Blood Pressure
- o Heart Murmur/Irregular Heart Rhythm
- o Other: _____
- o None

D. METABOLIC/ENDOCRINE
- o Diabetes Requires Insulin? YES or NO
- o Thyroid Disorder
- o Other: _____
- o None

E. HEAD/NEUROLOGICAL
- o Autism or Asperger's Syndrome
- o Cerebral Palsy
- o Migraines
- o Seizure Disorders If so, list date of Last seizure_____
- o Spina Bifida
- o Tourette's Syndrome
- o Traumatic Brain Injury (TBI)
- o Other:_____
- o None

F. EYES/HEARING
- o Vision Impaired
- o Hearing Impaired
- o Wears Hearing Aids
- o Other: _____

None

D. BEHAVIORAL OR SOCIAL	Has your child ever been hospitalized for the any of the condition(s) checked?
o Anxiety/Panic Attacks o Depression o Bipolar Disorder o Eating Disorder o ADD/ADHD o OCD o PTSD o Other _____ None	o Yes o No If **Yes**, please list date and reason: _____ _____

Has your child ever stopped breathing or needed CPR? YES or NO

Has your child suffered a concussion in the past year? YES or NO

Please list all medications (prescription and non-prescription) your student takes: (In case of an emergency, we need this information to share with EMS)

1. _____ **Additional Information:**
2. _____
3. _____
4. _____
5. _____

Does your Child need any prescription or non-prescription medication to be given at school? YES or NO

If YES, a Medication or Action form must be completed and signed by the parent/guardian and Physician each year. Please refer to our website under the Parents Tab/Forms & Resources for the appropriate forms.

For Parents of Rising 7th Graders – Please make sure they have all the required Immunizations and Documentation prior to the new school year. Please contact your pediatrician if you have any questions regarding these immunizations or NC Requirements. These will have to be turned into the office prior to the first day of school, August 18, 2020.

As parent or legal guardian of_____, I hereby grant permission for any treatment deemed necessary for a condition arising at (THE FRANKLIN SCHOOL OF INNOVATION). Treatment may be given by emergency personnel or a first responder as necessary. I understand every effort will be made to contact me prior to treatment. I also give pertinent (THE FRANKLIN SCHOOL OF INNOVATION) staff permission to obtain and review medical information provided of the above named student, and understand that this information will remain confidential and will only be used in the care and treatment of the above named student.

Parent/Guardian Name(s): _____

Parent/Guardian Signature(s):_____ Date:_____